FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029199

Facility Name: BURGESS SQUARE HC CENTRE

Address: 5801 S. CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (630) 971-2645 **Fax #** (630) 971-1961

IDPA ID Number: 363328030001

Date of Initial License for Current Owners: 04/04/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) ROBERT A. ROSE, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,745	1,393	3,437	7,575	8
9	SNF/PED					9
10	ICF	29,040	24,412		53,452	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,785	25,805	3,437	61,027	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.24%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 2695

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	431,570	46,997	12,503	491,070		491,070		491,070			1
2	Food Purchase		314,907		314,907		314,907	(1,332)	313,575			2
3	Housekeeping	283,739	42,520		326,259		326,259		326,259			3
4	Laundry	76,962	46,554		123,516		123,516		123,516			4
5	Heat and Other Utilities			183,027	183,027		183,027		183,027			5
6	Maintenance	103,254	51,745	66,716	221,715		221,715	(17,581)	204,134			6
7	Other (specify):*											7
8	TOTAL General Services	895,525	502,723	262,246	1,660,494		1,660,494	(18,913)	1,641,581			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,225,586	96,128	428,030	2,749,744		2,749,744		2,749,744			10
10a	Therapy			20,337	20,337		20,337		20,337			10a
11	Activities	108,890	21,912	2,424	133,226		133,226		133,226			11
12	Social Services	436,758		2,070	438,828		438,828		438,828			12
13	Nurse Aide Training			3,393	3,393		3,393		3,393			13
14	Program Transportation			379	379		379		379			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,771,234	118,040	465,633	3,354,907		3,354,907		3,354,907			16
	C. General Administration											
17	Administrative	87,490		312,362	399,852		399,852	(17,390)	382,462			17
18	Directors Fees											18
19	Professional Services			80,460	80,460		80,460	(3,028)	77,432			19
20	Dues, Fees, Subscriptions & Promotions			71,890	71,890		71,890	(24,204)	47,686			20
21	Clerical & General Office Expenses	158,392	43,533	66,635	268,560		268,560	(18,014)	250,546			21
22	Employee Benefits & Payroll Taxes			592,492	592,492		592,492		592,492			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,383	2,383		2,383	(905)	1,478			24
25	Other Admin. Staff Transportation			7,863	7,863		7,863	(4,699)	3,164			25
26	Insurance-Prop.Liab.Malpractice			122,806	122,806		122,806		122,806			26
27	Other (specify):*							14,373	14,373			27
28	TOTAL General Administration	245,882	43,533	1,256,891	1,546,306		1,546,306	(53,867)	1,492,439			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,912,641	664,296	1,984,770	6,561,707		6,561,707	(72,780)	6,488,927			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BURGESS SQUARE HC CENTRE #0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			60,747	60,747		60,747	26,530	87,277			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,838	6,838		6,838	(6,838)				32
33	Real Estate Taxes			99,157	99,157		99,157		99,157			33
34	Rent-Facility & Grounds			826,722	826,722		826,722		826,722			34
35	Rent-Equipment & Vehicles			1,199	1,199		1,199		1,199			35
36	Other (specify):*											36
37	**TOTAL Ownership**			994,663	994,663		994,663	19,692	1,014,355			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,494	48,474	153,968		153,968		153,968			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		105,494	163,997	269,491		269,491		269,491			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,912,641	769,790	3,143,430	7,825,861		7,825,861	(53,088)	7,772,773			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,581	30		9
10	Interest and Other Investment Income	(1,538)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,332)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,720)	21		18
19	Entertainment				19
20	Contributions	(4,210)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,532)	21		24
25	Fund Raising, Advertising and Promotional	(15,830)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(147)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(748)	20		28
29	Other-Attach Schedule	(32,394)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,870)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(5,218)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (5,218)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,088)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BURGESS SQUARE HC CENTRE

ID# 0029199

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	INTEREST SHAREHOLDER LOAN	$ (404)	32	1
2	NON ALOWABLE ACCOUNTING FEES	(2,946)	19	2
3	PUBLIC RELATIONS RESIDENT RELATED	(3,780)	20	3
4	OUT OF PERIOD LEGAL FEES	(1,392)	19	4
5	BANK CHARGES	(571)	21	5
6	CAPITALIZED R&M	(17,581)	6	6
7	NON CARE ASSET DEPRECIATION	(51)	30	7
8	GOLF TOURNAMENT	(620)	24	8
9	OUT OF STATE SEMINAR EXP	(350)	24	9
10	OUT OF STATE TRAVEL	(3,867)	25	10
11	NON ALLOWABLE TRAVEL	(832)	25	11
12				12
13				13
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,332)											(1,332)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(17,581)											(17,581)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(18,913)											(18,913)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(312,362)	294,972								(17,390)	17
18	Directors Fees													18
19	Professional Services	(4,338)		1,310									(3,028)	19
20	Fees, Subscriptions & Promotions	(24,568)		364									(24,204)	20
21	Clerical & General Office Expenses	(18,970)		45	911								(18,014)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(970)		65									(905)	24
25	Other Admin. Staff Transportation	(4,699)											(4,699)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*				14,373								14,373	27
28	**TOTAL General Administration**	(53,545)		(310,578)	310,256								(53,867)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,458)		(310,578)	310,256								(72,780)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	26,530											26,530	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,942)		(4,896)									(6,838)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	24,588		(4,896)									19,692	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,870)		(315,474)	310,256								(53,088)	45

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jacqueline Mason	70.00%			UNITED CARE	KENILWORTH	MANAGEMENT C
Monty Miller	30.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	UNITED CARE INC.	100.00%	$ 1,310	$ 1,310	15
16	V	20	DUES, SUBSCRIPTIONS				364	364	16
17	V	21	CLERICAL AND GENERAL				45	45	17
18	V	24	SEMINARS				65	65	18
19	V	32	INTEREST				(4,896)	(4,896)	19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEE	312,362				(312,362)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 312,362			$ (3,112)	$ * (315,474)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	UNITED CARE INC.	100.00%	$ 165,615	$ 165,615	15
16	V	27	EMPLOYEE BENEFITS				7,496	7,496	16
17	V								17
18	V								18
19	V	17	ADMINISTRATIVE				129,357	129,357	19
20	V	21	CLERICAL AND GENERAL				911	911	20
21	V	27	EMPLOYEE BENEFITS				6,877	6,877	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 310,256	$ * 310,256	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jacqueline Mason	President	Administrative	70.00%	See Attached	35	70.00%	Salary-United	$ 165,615	17-7	1
2	Monty Miller	Vice President	Administrative	30.00%	See Attached	40	100.00%	Salary-United	129,357	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 294,972		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: UNITED CARE INC.
Street Address: 145 TUDOR PLACE
City / State / Zip Code: KENILWORTH, IL. 60043
Phone Number: (630)971-2645
Fax Number: (630)971-1961

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	MGMT. FEE INCOME	312,362	1	$ 1,310	$	312,362	$ 1,310	1
2	20	DUES, SUBSCRIPTIONS	MGMT. FEE INCOME	312,362	1	364		312,362	364	2
3	21	CLERICAL AND GENERAL	MGMT. FEE INCOME	312,362	1	45		312,362	45	3
4	24	SEMINARS	MGMT. FEE INCOME	312,362	1	65		312,362	65	4
5	32	INTEREST	MGMT. FEE INCOME	312,362	1	(4,896)		312,362	(4,896)	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ (3,112)	$		$ (3,112)	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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City / State / Zip Code: KENILWORTH, IL. 60043
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Fax Number: (630)971-1961

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG HOURS-MASON	35	1	165,615	165,615	35	165,615	1
2	27	EMPLOYEE BENEFITS	AVG HOURS-MASON	35	1	7,496		35	7,496	2
3										3
4										4
5	17	ADMINISTRATIVE	AVG HOURS-MILLER	40	1	129,357	122,935	40	129,357	5
6	21	CLERICAL AND GENERAL	AVG HOURS-MILLER	40	1	911		40	911	6
7	27	EMPLOYEE BENEFITS	AVG HOURS-MILLER	40	1	6,877		40	6,877	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 310,256	$ 288,550		$ 310,256	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LASALLE NATIONAL BANK		X	LINE OF CREDIT	Interest only		$	$ 199,955		5.25%	$ 5,383	1
2			X	AUTO	$370	12/10/98	18,036	8,141	12/10/03	8.50%	859	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$370		$ 18,036	$ 208,096			$ 6,242	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(6,243)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,243)	14
15	TOTALS (line 9+line14)						$ 18,036	$ 208,096			$ (1)	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income Related Party	X					$	$			$ (4,896)	1
2	Insurance Financing		X								192	2
3	Interest Income		X								(1,539)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (6,243)	21

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 79,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 88,205	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,305	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 90,852	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 99,157	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	76,987	8
	1997	75,247	9
	1998	77,597	10
	1999	77,574	11
	2000	88,205	12

2001 Accrual = 2000 RE TAX EXP 88205*1.03 = 90,852

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BURGESS SQUARE HC CENTRE COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0029199

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-107-012	LONG TERM CARE	$ 88,205.00	$ 88,205.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,205.00	$ 88,205.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,000 B. General Construction Type: Exterior BRICK Frame STEEL STRUCTURE Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	86,486		20	4,273	4,273	70,722	9
10	Various			1986	87,317		20	732	732	86,294	10
11	Various			1987	10,202		20	300	300	10,011	11
12	Various			1988	11,485		20	574	(574)	7,735	12
13	Various			1989	25,270		20	1,264	1,264	15,960	13
14	Various			1990	52,220		20	2,612	2,612	31,131	14
15	Various			1991	27,798		20	2,019	2,019	25,170	15
16	Various			1992	12,659		20	633	633	5,873	16
17	Various			1993	342,712		20	17,135	17,135	140,799	17
18	Various			1994	16,249		20	813	813	6,346	18
19	Various			1995	20,503		20	1,025	1,025	6,677	19
20	Various			1996	23,823		20	1,191	1,191	6,413	20
21	Various			1997	29,589		20	1,479	1,479	6,864	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			60,696			(60,696)		69
70	TOTAL (lines 4 thru 69)		$ 746,313	$ 60,696		$ 34,050	$ (27,794)	$ 419,995	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 746,313	$ 60,696		$ 34,050	$ (26,646)	$ 419,995	1
2	HEATING UNIT	1998	8,600		20	430	430	1,684	2
3	DINING ROOM	1998	1,144		20	57	57	219	3
4	CABLE IN WALL	1998	750		20	38	38	146	4
5	WALL SWITCHES	1998	2,022		20	101	101	387	5
6	PLUMBING	1998	7,113		20	356	356	1,305	6
7	ELEVATOR R&M	1998	1,613		20	81	81	297	7
8	A/C R&M	1998	1,319		20	66	66	242	8
9	CONCRETE DRIVE	1998	3,270		20	164	164	588	9
10	PLUMBING	1998	5,410		20	271	271	971	10
11	WATER HEATER	1998	4,600		20	230	230	748	11
12	HEATING REPAIR	1998	861		20	43	43	140	12
13	BLOWER-HVAC	1999	2,776		20	139	139	417	13
14	PLUMBING	1999	3,500		20	175	175	510	14
15	GENERATOR R&M	1999	3,862		20	193	193	563	15
16	ASPHALT PARKING LOT	1999	13,750		20	688	688	1,777	16
17	ARCHITECT-LAUNDRY	1999	1,508		20	75	75	188	17
18	GENERATOR R&M	1999	1,831		20	92	92	253	18
19	GENERATOR R&M	1999	588		20	29	29	75	19
20	LAUNDRY RM REHAB	1999	19,630		20	982	982	2,291	20
21	LAUNDRY RM REHAB	1999	1,026		20	51	51	119	21
22	WATER HEATER	1999	4,836		20	242	242	585	22
23	HVAC UNIT-ROOF	1999	20,165		20	1,008	1,008	2,268	23
24	DOOR HOLDERS	1999	843		20	42	42	91	24
25	DOOR MAGNET LOCKS	1999	1,487		20	74	74	160	25
26	ELEVATOR R&M	1999	2,193		20	110	110	257	26
27	ELEVATOR R&M	1999	1,687		20	84	84	189	27
28	HEATING R&M	1999	600		20	30	30	63	28
29	FIRE DOOR	1999	841		20	42	42	88	29
30	PLUMBING	1999	722		20	36	36	102	30
31	SPRINKLER HEAD	1999	647		20	32	32	67	31
32	HVAC R&M	1999	662		20	33	33	80	32
33	SECURITY SYSTEM	1999	925		20	46	46	104	33
34	TOTAL (lines 1 thru 33)		$ 867,094	$ 60,696		$ 40,090	$ (20,606)	$ 436,969	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 867,094	$ 60,696		$ 40,090	$ (20,606)	$ 436,969	1
2	DOOR LOCK	1999	1,602		20	80	80	180	2
3	SECURITY SYSTEM	1999	1,222		20	61	61	137	3
4	SHUT OFF VALVE	1999	1,099		20	55	55	128	4
5	PLUMBING	2000	597		20	30	30	53	5
6	PLUMBING	2000	664		20	33	33	63	6
7	MAINTENCE	2000	790		20	40	40	67	7
8	ARCHITECT FEES	2000	1,466		20	73	73	128	8
9	ELTON/MOTOR DRIVE	2000	569		20	28	28	47	9
10	ELTON/ELECTRICAL	2000	591		20	30	30	43	10
11	NEW COMPRESSOR	2000	1,381		20	69	69	115	11
12	ELEVATOR R&M	2000	2,700		20	135	135	259	12
13	ELECTRICAL	2000	12,000		20	600	600	1,150	13
14	J&K ROOFING	2000	4,500		20	225	225	413	14
15	ELECTRICAL	2000	2,525		20	126	126	231	15
16	CEILINGS	2000	12,637		20	632	632	1,211	16
17	ROOFING	2000	52,500		20	2,625	2,625	4,813	17
18	FIRE DAMPERS	2000	26,595		20	1,330	1,330	2,438	18
19	ELECTRICAL - GENER	2000	12,000		20	600	600	1,100	19
20	WATER HEATER	2000	4,897		20	245	245	408	20
21	GENERATOR	2000	28,376		20	1,419	1,419	2,365	21
22	ARCHITECT FEES - GEN	2000	615		20	31	31	52	22
23	ELECTRICAL - GENER	2000	14,625		20	731	731	1,218	23
24	ELECTRICAL	2000	6,000		20	300	300	500	24
25	GENERATOR REPAIR	2000	1,510		20	76	76	114	25
26	VENT SYSTEM	2000	1,068		20	53	53	106	26
27	ELECTRICAL	2000	5,000		20	250	250	354	27
28	PUMP	2000	1,590		20	80	80	87	28
29	ELEVATOR IMPROVEMENT	2001	2,150		20	108	108	108	29
30	HOT WATER TANK	2001	5,646		20	259	259	259	30
31	ROOF IMPROVEMENT	2001	11,275		20	470	470	470	31
32	DOORS	2001	1,595		20	60	60	60	32
33	ELECTRICAL WALL PAKS	2001	1,258		20	42	42	42	33
34	TOTAL (lines 1 thru 33)		$ 1,088,137	$ 60,696		$ 50,986	$ (9,710)	$ 455,688	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,088,137	$ 60,696		$ 50,986	$ (9,710)	$ 455,688	1
2	ELECTRICAL WORK	2001	1,795		20	30	30	30	2
3	CARPETS	2001	5,009		20	167	167	167	3
4	SIGNS	2001	3,000		20	100	100	100	4
5	HVAC UNIT	2001	11,500		20	144	144	144	5
6	HVAC UNIT	2001	11,500		20	96	96	96	6
7	SIGNS	2001	930		20	16	16	16	7
8	SIGNS	2001	2,526		20	42	42	42	8
9	PLUMBING	2001	11,314		20	47	47	47	9
10	CARPENTRY	2001	1,607		20	7	7	7	10
11	CALL STATION	2001	1,536		20	76	76	76	11
12	NETWORK CABLES	2001	987		20	49	49	49	12
13	TELEPHONE	2001	770		20	38	38	38	13
14	ELECTRIC RANGE	2001	1,036		20	51	51	51	14
15	CALL STATION	2001	568		20	28	28	28	15
16	TILE	2001	582		20	29	29	29	16
17	TILE	2001	1,187		20	59	59	59	17
18	TELEPHONE	2001	599		20	30	30	30	18
19	PLUMBING	2001	809		20	40	40	40	19
20	HEAT EXCHANGER	2001	1,400		20	70	70	70	20
21	TILE	2001	539		20	26	26	26	21
22	SECURITY SYSTEM	2001	1,072		20	53	53	53	22
23	HEAT EXCHANGER	2001	710		20	35	35	35	23
24	TIME CLOCK/LIGHTS AND SIGN	2001	1,395		20	69	69	69	24
25	BLOWER/IGNITOR	2001	652		20	32	32	32	25
26	COOLER	2001	1,226		20	61	61	61	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,152,386	$ 60,696		$ 52,381	$ (8,315)	$ 457,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 354,113	$	$ 27,062	$ 27,062	10	$ 228,676	71
72	Current Year Purchases	54,973		3,350	3,350	10	3,350	72
73	Fully Depreciated Assets	113,462				10	113,462	73
74								74
75	TOTALS	$ 522,548	$	$ 30,412	$ 30,412		$ 345,488	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY BUSINESS	VAN	1998	$ 22,421	$	$ 4,484	$ 4,484	5	$ 13,826	76
77										77
78										78
79										79
80	TOTALS			$ 22,421	$	$ 4,484	$ 4,484		$ 13,826	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,697,355	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 60,696	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 87,277	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,581	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 816,397	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	A/C R&M - 1998	$ 1,014	$ 51	$ 183	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 1,014	$ 51	$ 183	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CAMELOT HEALTHCARE CENTRE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		211		$ 823,987			3
4	Additions							4
5	STORAGE				2,735			5
6								6
7	TOTAL		211		$ 826,722 **			7

10. Effective dates of current rental agreement:
Beginning 12/01/84
Ending 11/30/09

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 823,988
13.	/2003	$ 823,988
14.	/2004	$ 823,988

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: NOV. 30, 2009 $7,140,000 *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,199 Description: Pitney Bowes-Postage Machine $1,019 , Simplex Time - Time Clock $180
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		2,843		2,843
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		550		550
9	TOTALS	$	$ 3,393	$	$ 3,393
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,393			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 22,658	$		$ 22,658	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,232			2,232	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			23,584			23,584	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				53,974		53,974	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						51,520		51,520	13
14	TOTAL			$		$ 48,474	$ 105,494		$ 153,968	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 154,280	$	1
2	Cash-Patient Deposits	32,798		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,195,527		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	203,505		6
7	Other Prepaid Expenses	16,551		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	11,908		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,614,569	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,081,858		15
16	Equipment, at Historical Cost	548,926		16
17	Accumulated Depreciation (book methods)	(774,018)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 856,766	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,471,335	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 415,574	$	26
27	Officer's Accounts Payable	50,000		27
28	Accounts Payable-Patient Deposits	32,565		28
29	Short-Term Notes Payable	204,395		29
30	Accrued Salaries Payable	169,293		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,934		31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,852		32
33	Accrued Interest Payable	622		33
34	Deferred Compensation	274,487		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,254,722	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,701		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,701	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,258,423	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,212,912	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,471,335	$	48

*(See instructions.)

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,831,703	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,831,703	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(44,819)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(573,972)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (618,791)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,212,912	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,540,985	1
2	Discounts and Allowances for all Levels	(228,641)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,312,344	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,515	6
7	Oxygen	3,051	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 265,566	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,180	19
20	Radiology and X-Ray	4,622	20
21	Other Medical Services	152,015	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 198,817	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,470	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,470	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,845	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,845	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,781,042	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,660,494	31
32	Health Care	3,354,907	32
33	General Administration	1,546,306	33
	B. Capital Expense		
34	Ownership	994,663	34
	C. Ancillary Expense		
35	Special Cost Centers	153,968	35
36	Provider Participation Fee	115,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,825,861	40
41	**Income before Income Taxes (line 30 minus line 40)****	(44,819)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (44,819)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,080	$ 67,084	$ 32.25	1
2	Assistant Director of Nursing	1,856	1,928	55,720	28.90	2
3	Registered Nurses	28,234	36,197	787,289	21.75	3
4	Licensed Practical Nurses	12,991	14,763	311,211	21.08	4
5	Nurse Aides & Orderlies	71,518	88,045	957,327	10.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,687	6,255	108,890	17.41	9
10	Activity Assistants					10
11	Social Service Workers	29,168	34,876	436,758	12.52	11
12	Dietician					12
13	Food Service Supervisor	4,041	4,976	85,513	17.19	13
14	Head Cook	3,857	5,079	66,740	13.14	14
15	Cook Helpers/Assistants	24,049	29,531	279,317	9.46	15
16	Dishwashers					16
17	Maintenance Workers	5,335	7,887	103,254	13.09	17
18	Housekeepers	19,791	24,678	283,739	11.50	18
19	Laundry	6,731	8,501	76,962	9.05	19
20	Administrator	2,024	2,160	87,490	40.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,428	5,787	158,392	27.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,763	4,140	46,955	11.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	226,425	276,883	$ 3,912,641 *	$ 14.13	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 12,503	01-03	35
36	Medical Director	MONTHLY	9,000	09-03	36
37	Medical Records Consultant	MONTHLY	3,582	10-03	37
38	Nurse Consultant	1,795	44,895	10-03	38
39	Pharmacist Consultant	MONTHLY	2,020	10-03	39
40	Physical Therapy Consultant	155	8,203	10a-03	40
41	Occupational Therapy Consultant	193	10,238	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	54	1,896	10a-03	43
44	Activity Consultant	52	2,424	11-03	44
45	Social Service Consultant	41	2,070	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,290	$ 96,831		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,070	$ 56,989	10-03	50
51	Licensed Practical Nurses	1,836	72,897	10-03	51
52	Nurse Aides	12,292	247,647	10-03	52
53	TOTAL (lines 50 - 52)	15,198	$ 377,533		53

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOANNE FISHER	ADMINISTRATOR		$ 87,490
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,490

B. Administrative - Other

Description	Amount
UNITED CARE, INC.	$ 312,362
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 312,362

C. Professional Services

Vendor/Payee	Type	Amount
Lawrence Schwartz	LEGAL	$ 340
Stone, McGuire, Benjamin	LEGAL	3,257
Duane, Morris & Heckscher	LEGAL	12
Mulherin, Rehfeldt & Varchetto	LEGAL	370
Frost, Ruttenberg & Rothblatt	ACCOUNTING	71,881
Add On	DATA PROCESSING	920
Mutual Of Omaha	DATA PROCESSING	322
Accu Med	DATA PROCESSING	3,358
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 80,460

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,001
Unemployment Compensation Insurance	20,901
FICA Taxes	302,587
Employee Health Insurance	179,322
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K CONTRIBUTION	9,746
MISC EMPLOYEE BENEFITS	13,935
TOTAL (agree to Schedule V, line 22, col.8)	$ 592,492

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	33,964
Health Care Worker Background Check	
(Indicate # of checks performed 181)	2,174
DUES,FEES,SUBSCRIPTIONS	9,782
ADVERTISING	15,830
PUBLIC RELATIONS RESIDENTS	3,780
YELLOW PAGE ADVERTISING	748
LIC AND FEES	1,201
ALLOC FROM UNITED CARE	364
Less: Public Relations Expense	(15,830)
Non-allowable advertising	(3,780)
Yellow page advertising	(748)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,685

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,413
ALLOCATION FROM UNITED CARE	65
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,478

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BURGESS SQUARE HC CENTRE # 0029199 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL HEALTH CARE ASSOC. $12,056**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **20 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,926** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,523**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees